ATTENTION: SMALL EMPLOYERS (THOSE WITH LESS THAN 8 REGULAR EMPLOYEES) SUBJECT TO HAWAII'S PREPAID HEALTH CARE (PHC) ACT, CHAPTER 393*, HRS

A special fund for health care premium supplementation is available to employers who meet the criteria established under Section 393-45, HRS. A claim for premium supplementation must be filed with the Department of Labor and Industrial Relations within two years after the end of the employer's taxable year.

Section 393-45 of the PHC Act specifies that an employer is entitled to premium supplementation if the employer satisfies **all** of the following qualifying conditions:

1. Employer employs less than eight employees entitled to PHC coverage.

2. The employer's health care plan is approved under Section 393-7(a) of the PHC Act.

3. Employer's share of the premium cost for eligible employees (single coverage only) exceeds 1.5% of the total wages payable to such employees and the amount of such excess is greater than 5% of the employer's income before taxes directly attributable to the business.

4. The fund will not supplement employee's share of the premium, dependent's coverage and the additional premium cost for the more expensive plan should the employer have more than one plan.

If you meet the above criteria, contact the Disability Compensation Division at (808) 586-9199 and ask for Form HC-6, Employer's Request for Premium Supplementation.

Complete Form HC-6 and return it with the following documents:

1. Individual payroll records
2. Certified copy of State of Hawaii income tax return for the business
3. U.S. income tax return for the business
4. Quarterly payroll tax reports (Forms UC-B6 and 941)
5. Form W-2, wage and tax statement
6. Health care contractor's monthly medical billing statements
7. Any other related documents pertaining to the request for PHC premium supplementation
8. Temporary disability insurance premium statements

*Visit www.uhwo.hawaii.edu/clear/HRS393.html for complete text of Chapter 393, HRS, where you can find the sections that are referenced above.

Form HC-6
(Rev. 11/02)

State of Hawaii
Department of Labor and Industrial Relations
Disability Compensation Division
P.O. Box 3769
Honolulu, Hawaii 96812-3769

EMPLOYER'S REQUEST FOR PREMIUM SUPPLEMENTATION

Employer Name and Address	DOL Account No.

1. Health Care Contractor Name: _____

2. Plan Name: _____

3. Total number of employees eligible for PHC coverage: _____

4. Total annual wages paid to employees eligible for **and** covered under employer's PHC plan $_____

To calculate premium supplementation:

A. Total annual premium cost for providing single PHC coverage to eligible employees (per billing statements from health care contractor) $_____

B. Employees' share of premium cost (l.5% of employee's wages not to exceed 50% of premium cost) $_____

C. Employer's share of the premium cost $_____
(A minus B)

D. 1.5% of total wages paid to covered eligible employees $_____

E. Difference (Stop here if E is not a positive number. You are not entitled to premium supplementation.) $_____
(C minus D)

F. 5% of employer's adjusted income before taxes directly attributable to the business (Leave blank if not known.) $_____

G. This is an approximate amount of premium supplementation claimed (If G is positive, you may be entitled to premium supplementation.) $_____
(E minus F)

5. Period for which premium supplementation covers is from _____ to _____(taxable year)

Attached with my application are individual payroll records, U.S. income tax return for the business, certified copy of State of Hawaii income tax return, quarterly payroll tax reports (Forms UC-B6 and 941), Form W-2, wage and tax statement, health care contractor's monthly medical billing statements, temporary disability insurance premium statements, and all related documents pertaining to my request for PHC premium supplementation.

I certify that the information submitted above is true and correct to the best of my knowledge. I understand that the Department of Labor and Industrial Relations, Disability Compensation Division, reserves the right to audit company records in considering our request.

Authorized Signature	Date
Print Name and Title	Telephone No.
	FAX No.

FOR OFFICE USE ONLY

❑ Approved Amount $_____ Period _____ to _____
❑ Disapproved because _____
_____

Audited by _____ Date _____
Approved by _____ Date _____